STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G184	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	1818 H ST BEDFORD, IN 47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This visit was for a focused fundamental recertification and state licensure survey. Survey Dates: December 9, 10 and 11, 2019 Facility Number: 000717 Provider Number: 15G184 AIM Number: 100234700 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/19/19.	W 000		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility's governing body failed to exercise operating direction over the facility by failing to ensure the home remained in good repair. Findings include: On 12/9/19 from 3:35 PM to 5:55 PM and 12/10/19 from 5:57 AM to 7:55 AM, observations were conducted at the group home. The following issues were noted affecting clients #1, #2, #3, #4, #5, #6, #7 and #8:	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 104	Continued From page 1 1) The sidewalk in the front of the house was uneven with cracked and crumbling concrete. 2) The concrete on the front porch was cracked, crumbling and uneven. 3) The upstairs bathroom exhaust vent was clogged with dust and lint. 4) The countertop the kitchen sink was installed in was pulled away from the wall. There were gaps on the left and the right side behind the sink where the countertop moved away from the back wall. 5) The carpet in the upstairs hallway was bunched up causing a trip hazard in front of client #1's, #6's and #8's bedroom door. On 12/9/19 at 12:56 PM, the Home Manager (HM) stated the facility was "still working on items from last year that haven't been repaired." The HM indicated the countertops and cabinets were measured on 11/26/19. The HM indicated the kitchen countertops needed to be replaced. The HM indicated the sidewalk was not repaired. The HM indicated the front porch's concrete was uneven and crumbling. On 12/10/19 at 10:17 AM, the HM indicated the upstairs carpet was "bunched up" and "needs to be repaired." The HM indicated the bathroom fan needed to be cleaned. The HM indicated the front sidewalk and porch needed to be repaired due to the cracks and uneven surfaces. The HM stated the sidewalk and front porch were a "fall risk." 9-3-1(a)	W 104		
W 157	STAFF TREATMENT OF CLIENTS	W 157		

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W 157	Continued From page 2 CFR(s): 483.420(d)(4) If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on 1 of 1 incident/investigative report reviewed affecting client #4, the facility failed to ensure recommended corrective action following a fall with injury was implemented. Findings include: On 12/9/19 at 1:56 PM, a review of the facility's incident reports was conducted and indicated the following: On 6/10/19 at 3:15 PM, client #4 fell while in the kitchen. He hit the back of his head on the corner of the kitchen counter. He had a 6 centimeter laceration on the back of his head. He was transported to the hospital by ambulance where he received 8 staples to the laceration. The 6/17/19 Investigative Summary indicated the fall occurred on 6/10/19 between 8:00 PM to 8:15 PM. The report indicated in the Factual Findings section, "...The fall was an isolated incident and there was no one present in the kitchen except [client #4]. [Client #4] was in the kitchen to put his med cup away, fell backward, and hit the back of his head on the kitchen counter. [Staff #3] had [client #4] within his line of sight. The Fall risk plan states staff will provide close supervision...." The Conclusion section indicated, "...It is substantiated [staff #3] had [client #4] within his line of sight. It is substantiated the Fall risk plan was implemented correctly... It is substantiated there was no neglect as the Fall risk plan and	W 157		

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W 157	Continued From page 3	W 157		

universal precautions were properly implemented." The 6/19/19 Investigation Peer Review indicated in the Recommendations section, "Review Fall HRP (health risk plan) and define 'Close supervision.'"

There was no documentation "close supervision" was defined in client #4's risk plan after his fall.

On 12/10/19 at 10:24 AM, a focused review of client #4's record was conducted.
-On 6/11/19, client #4's Interdisciplinary Team (IDT) met to discuss the fall. There were no changes to client #4's risk plan. The IDT did not define close supervision.
-Client #4's February 2019 Risk Plan for falls indicated, in part, "...[Client #4] has had no falls in the past year... Staff will provide close supervision for [client #4] at all times...."
-Client #4's 7/29/19 Risk plan for falls indicated, in part, "...[Client #4] has fallen in the past... Staff will always provide close supervision for [client #4]...."

On 12/9/19 at 3:25 PM, the Home Manager (HM) indicated there were no changes to client #4's risk plan following his fall. The HM was unable to define "close supervision" as indicated in client #4's risk plan. The HM "close supervision" needed to be defined in client #4's risk plan. The HM stated "don't understand what that means."

On 12/10/19 at 9:27 AM, the Area Supervisor (AS) indicated staff did not fail to supervise him per his plan. The AS indicated client #4's plan required close supervision. The AS indicated there was no changes to client #4's risk plan following his fall. The AS indicated the recommendation to define "close supervision"

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W 157	Continued From page 4 should have been implemented as indicated in the investigation. The AS indicated close supervision needed to be defined. The AS indicated she could not define close supervision. On 12/11/19 at 11:48 AM, the Quality Assurance Manager (QAM) indicated client #4's risk plan should have been revised with a definition of "close supervision." On 12/10/19 at 2:51 PM, the Director of Nursing (DON) indicated the former nurse assigned to the home was asked to update client #4's risk plan. The DON stated the update to the plan "was not sufficient." The DON indicated client #4's plan needed to clarify the close supervision part. The DON indicated close supervision needed to be defined. On 12/9/19 at 3:25 PM, the Home Manager indicated there were no changes to client #4's fall risk plan after he had a fall with injury. The Home Manager indicated, after reviewing the plan in place at the time of the fall and the revised plan, the change she saw was he would have no falls through 2020. The Home Manager indicated there were no additional changes to his supervision level.	W 157		
W 240	9-3-2(a) INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence.	W 240		

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W 240	Continued From page 5	W 240		

This STANDARD is not met as evidenced by:
Based on record review and interview for 1 of 4 non-sampled clients (#4), the facility failed to ensure client #4's fall risk plan was revised, as recommended, following a fall with injury.

Findings include:

On 12/9/19 at 1:56 PM, a review of the facility's incident reports was conducted and indicated the following:

On 6/10/19 at 3:15 PM, client #4 fell while in the kitchen. He hit the back of his head on the corner of the kitchen counter. He had a 6 centimeter laceration on the back of his head. He was transported to the hospital by ambulance where he received 8 staples to the laceration. The 6/17/19 Investigative Summary indicated the fall occurred on 6/10/19 between 8:00 PM to 8:15 PM. The report indicated in the Factual Findings section, "...The fall was an isolated incident and there was no one present in the kitchen except [client #4]. [Client #4] was in the kitchen to put his med cup away, fell backward, and hit the back of his head on the kitchen counter. [Staff #3] had [client #4] within his line of sight. The Fall risk plan states staff will provide close supervision...." The Conclusion section indicated, "...It is substantiated [staff #3] had [client #4] within his line of sight. It is substantiated the Fall risk plan was implemented correctly... It is substantiated there was no neglect as the Fall risk plan and universal precautions were properly implemented." The 6/19/19 Investigation Peer Review indicated in the Recommendations section, "Review Fall HRP (health risk plan) and define 'Close supervision.'"

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W 240	Continued From page 6	W 240		

There was no documentation "close supervision" was defined in client #4's risk plan after his fall.

On 12/10/19 at 10:24 AM, a focused review of client #4's record was conducted.
-On 6/11/19, client #4's Interdisciplinary Team (IDT) met to discuss the fall. There were no changes to client #4's risk plan. The IDT did not define close supervision.
-Client #4's February 2019 Risk Plan for falls indicated, in part, "...[Client #4] has had no falls in the past year... Staff will provide close supervision for [client #4] at all times...."
-Client #4's 7/29/19 Risk plan for falls indicated, in part, "...[Client #4] has fallen in the past... Staff will always provide close supervision for [client #4]...."

On 12/9/19 at 3:25 PM, the Home Manager (HM) indicated there were no changes to client #4's risk plan following his fall. The HM was unable to define "close supervision" as indicated in client #4's risk plan. The HM "close supervision" needed to be defined in client #4's risk plan. The HM stated "don't understand what that means."

On 12/10/19 at 9:27 AM, the Area Supervisor (AS) indicated staff did not fail to supervise him per his plan. The AS indicated client #4's plan required close supervision. The AS indicated there was no changes to client #4's risk plan following his fall. The AS indicated the recommendation to define "close supervision" should have been implemented as indicated in the investigation. The AS indicated close supervision needed to be defined. The AS indicated she could not define close supervision.

On 12/11/19 at 11:48 AM, the Quality Assurance

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W 240	Continued From page 7 Manager (QAM) indicated client #4's risk plan should have been revised with a definition of "close supervision." On 12/10/19 at 2:51 PM, the Director of Nursing (DON) indicated the former nurse assigned to the home was asked to update client #4's risk plan. The DON stated the update to the plan "was not sufficient." The DON indicated client #4's plan needed to clarify the close supervision part. The DON indicated close supervision needed to be defined. On 12/9/19 at 3:25 PM, the Home Manager indicated there were no changes to client #4's fall risk plan after he had a fall with injury. The Home Manager indicated, after reviewing the plan in place at the time of the fall and the revised plan, the change she saw was he would have no falls through 2020. The Home Manager indicated there were no additional changes to his supervision level. 9-3-4(a)	W 240		